Black Males, Trauma, and Mental Health Service Use: A Systematic Review

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Abstract

Objective: To systematically review the evidence of and synthesize results from relevant studies that have examined barriers and facilitators to professional mental health service use for Black male trauma survivors ages 18 and older. **Methods**: A thorough search of selected databases that included EBSCO, ProQuest, and Web of Science Core Collection and careful consideration of inclusion and exclusion criteria yielded a final six studies for detailed review. **Results**: Black male trauma survivors were significantly less likely to be utilizing mental health services than other sex-ethnic groups. High levels of daily crises, a lack of knowledge of steps to obtain services, and service eligibility issues were significant individual barriers to mental health service use for Black males, whereas social support, occupational disability, and PTSD symptoms severity were significant facilitators for mental health service use. **Conclusion**: Exposure to trauma, whether through witnessing or direct victimization, is often a daily reality for many Black males. Findings from this review suggest that 56-74% of Black males exposed to traumatic events may have an unmet need for mental health services. Future research examining the relationship between trauma and mental health service use for Black men and factors that moderate and/or mediate this relationship is warranted.

Key words: Black males, African-Americans, Mental Health, Trauma, Victimization

Background Literature

Each year trauma accounts for 41 million emergency department visits, 2.3 million hospital admissions and 192,000 deaths across the nation (National Trauma Institute, 2014). The American Psychiatric Association (2013) Diagnostic and Statistical Manual 5th edition (DSM-V) defines a traumatic event as exposure to actual or threatened death, serious injury, or sexual violence in the following ways:

> (1) Directly experiencing the traumatic event,
> (2) witnessing in person or as it occurred to others,
> (3) learning that the event occurred to a close family member or friend, and/or
> (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (p. 271)

Trauma has been identified as a major public health and medical issue, and Black males ages 18 and older are at a noticeably high risk for trauma exposure (Centers for Disease Control and Prevention, 2016; Davis et al., 2008; Fein, Wade, & Cronholm, 2013).

Studies examining trauma exposure among community samples of Black males show that approximately 62% have directly experienced a traumatic event in their lifetime, 72% witnessed a traumatic event, and 59% have learned of a traumatic event involving a friend or family member (Afful et al., 2010; Centers for Disease Control and Prevention, 2016; Davis et al., 2008; Fein, Wade, & Cronholm, 2013; Kilpatrick et al., 2013; Substance Abuse and Mental Health Services Administration, 2014; Tolin & Breslau, 2007). In addition, homicide rates for Black males are 26.77 per 100,000 compared to 2.67 per 100,000 for their White counterparts, and they are roughly three times more likely than White men to be victims of a nonfatal injury by firearm (Centers for Disease Control and Prevention, 2016). However, it is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event (Substance Abuse and Mental Health Services Administration, 2014). Although many Black males who experience a traumatic event will go on with their lives without incurring lasting negative outcomes, others may experience traumatic stress reactions that lead to deleterious mental and/or behavioral outcomes (Cuff & Matheson, 2015; Roberts et al., 2011).

Empirical research has documented an association between trauma and Post-Traumatic Stress Disorder (PTSD) (Breslau et al., 1999; Gillespie et al., 2009; Kessler et al., 2005), depression (Hovens et al., 2012; Mezuk et al., 2010; Williams et al., 2010; Wolff & Shi, 2012), anxiety (Gibb, Chelminski & Zimmerman, 2007; Kessler et al., 2010; Lochner et al., 2010; Mersky, Topitzes, & Reynolds, 2013), substance use (Dube et al., 2003; Mersky, Topitzes, & Reynolds, 2013; Reichert, Ruzich, & Osher, 2015; Rich & Grey, 2005; Turner & Lloyd, 2003), and violence perpetration (Gorman-Smith, Henry, & Tolan, 2004; Layne et al., 2014; Lynch & Cicchetti, 1998; Sansone, Leung, & Wiederman, 2012; Tummala–Narra et al., 2014). The frequency of trauma exposure among Black males ages 18 and older put them at great risk for experiencing one or more of these deleterious outcomes that may require mental health service use (Gary, 2005; Institute of Medicine, 2006; Snowden, 2003). Nevertheless, Black males are approximately half as likely as their White counterparts to use professional mental health services, even after adjusting for socioeconomic and clinical factors (Gonzalez et al., 2010; Hankerson et al., 2011).

Professional mental health services has been defined as formal facilities where specialized professionals (i.e., psychiatrist, psychologists, or licensed clinical social workers) provide specialized treatment to individuals with mental disorders that seeks to attenuate their symptomatology (Kessler et al., 2005). Mental health service use for Black males may be associated with certain factors that serve as barriers or facilitators to treatment use (Hines-Martin et al., 2003). According to the Behavioral Model of Health Services Use (Andersen, 1995) predisposing (e.g., age, gender, ethnicity, education), enabling (e.g., health insurance, income, social support), and need (e.g., symptom severity level, level of functional impairment) factors are associated with mental health service use for individuals in need of service. However, less is known about the relationship between predisposing, enabling, and need factors that may serve as barriers or facilitators to mental health service use for Black male trauma survivors. Thus, this study identified and synthesized results from relevant studies that have examined barriers and facilitators to mental health service use for Black male trauma survivors ages 18 and older. In addition, implications for future research, practice, and policy in this area are proposed.

Methods

The authors use the term "Black" and "African American" interchangeably throughout the paper to refer to a social, political, and culturally constructed ethnic group identity (Graves, 2001; Sussman, 2014; Zuberi, 2001) and recognize that this ethnic group, like all other ethnic groups in the United States, are heterogeneous. Literature searches were conducted between March 2016 and April 2016 in EBSCO (Academic Search Complete; America: History & Life; Applied Science & Technology Full Text [H.W. Wilson];CINAHL Plus; Communication Abstracts; Education Full Text [H.W. Wilson];Family & Society Studies Worldwide; Gender Studies Database; Global Health; Global Health Archive; History of Science, Technology & Medicine; MEDLINE; PsycINFO; Social Work Abstracts; SocINDEX), ProQuest (Applied Social Sciences Index and Abstracts Criminal Justice Database; Education Database; ERIC; Ethnic NewsWatch; Political Science Database; ProQuest Dissertations & Theses A&I; Social Science Database; Social Services Abstracts; Sociological Abstracts; Sociology Database), and Web of Science (Web of SCIENCE Core Collection; Inspec; KCI-Korean Journal Database; Russian Science Citation index; SciELO Citation Index).

Relevant articles were identified using search words formed according to the search guidelines and BOOLEAN combinations defined by the selected databases (see Table 1). Inclusion criteria for this review included articles that (1) were published after 1990, (2) were conducted in the U.S. (3) published in English (4) included Black males ages 18 and older, (4) measured trauma exposure, (5) measured mental health service use, (6) Assessed barriers to mental health service use, and/or, (7) assessed facilitators to mental health service use. The searches were completed by May, 2016. Titles and abstracts were screened, and articles were retrieved if they met the established inclusion criteria. Grey literature and the reference lists of retrieved papers were also screened to identify additional studies.

Table 1: Study Search Hedges

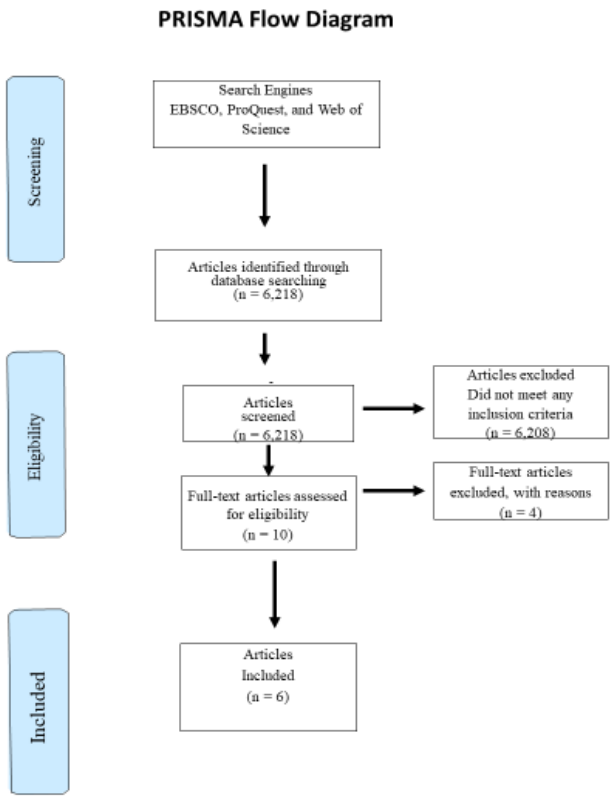
Category	Search Terms
Black	"african american" OR "african americans" OR "black" OR "blacks"
Men	"male" OR "males" OR "man" OR "men"
Trauma	"community violence" OR victim* OR "disaster" OR "disasters" OR witness* OR "emotional trauma" OR "emotionally traumatic" OR "psychological trauma" OR "psychologically traumatic" OR "emotional traumas" OR "psychological traumas" OR "psychosocial trauma" OR "psychosocial traumas" OR "rape trauma" OR "rape traumas" OR "psychological stress" OR "psychological stresses" OR "emotional stress" OR "emotional stresses" OR "psychologically stressed" OR "emotionally stressed" OR "stress disorder" OR "stress disorders" OR "stress disordered" OR "crisis" OR "domestic violence" OR "partner violence" OR "exposure to violence" OR "partner abuse" OR "husband abuse" OR "posttraumatic stress" OR "posttraumatic stresses" OR "post-traumatic stress" OR "post-traumatic stresses" OR "ptsd" OR "emotional abuse" OR "emotionally abused" OR "verbal abuse" OR "verbally abused" OR "anger" OR "perpetrator" OR" perpetrators" OR "neighborhood violence" OR "emotional distress" OR "emotionally distressed" OR "psychological distress" OR "psychologically distressed" OR "mental stress" OR "mental stresses" OR "mentally stressed" OR "mental distress" OR "mentally distressed" OR "mental trauma" OR "mental traumas" OR "mentally traumatic" OR "traumatic experience" OR "traumatic experiences" OR "traumatic event" OR "traumatic events" OR "traumatized" OR "violence survivor" OR "violence survivors" OR "rape survivor" OR "rape survivors" OR "trauma survivor" OR "trauma survivors"
Mental Health Services	"therapy" OR "therapies" OR "treatment" OR "treatments" OR "psychotherapy" OR "psychotherapies" OR "group work" OR "groupwork" OR "counseling" OR "behavior modification" OR "community psychology" OR "community based psychology" OR "community mental health" OR "community mental healthcare" OR "community based mental health" OR "community based mental healthcare" OR "hotline" OR "hotlines" OR "stress management" OR "crisis intervention" OR "crisis interventions" OR "anger management" OR "self-help group" OR "self-help groups" OR "support group" OR "support groups" OR "mental health" OR "psychological service" OR "psychological services" OR "psychological clinic" OR "psychological clinics" OR "psychological walk-in clinic" OR "psychological walk-in clinics" OR "psychological walkin clinic" OR "psychological walkin clinics" OR "mental healthcare" OR "psychotherapeutic intervention" OR "psychotherapeutic interventions" OR "therapeutic intervention" OR "therapeutic interventions" OR "health service utilization" OR "health services utilization" OR "health care utilization" OR "healthcare utilization"

Findings

A flow diagram for this review is presented in Figure 1. The Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) statement developed by Moher et al. (2009) was used as a guideline to formulate the flow diagram. An initial electronic search identified 6,218

studies published between January 1990 and April 2016 after exact duplicates were removed. The titles and abstracts of these articles were screened by the authors, resulting in 6,208 articles excluded because data was collected outside the U.S. or the outcomes studied did not meet the inclusion criteria. The remaining 10 studies were retrieved for full-text review. Four studies were excluded due to the sample not representing the population of interests, resulting in six studies that were included in the final research synthesis. Description of the studies design, sample, and setting are summarized in Table 2, and a description of how studies measured trauma exposure, mental health service use, and barriers or facilitators to mental health service use are summarized in Table 3.

Figure 1



Trauma Exposure and Mental Health Disorders

There were a variety of trauma exposures and accompanying mental health disorders for Black males in the studies reviewed. Rates for trauma exposure among Black males across studies varied by type of traumatic events that included physical abuse/assault (52%), sexual abuse (37%), serious accident/injury (52%), death of a loved one (59%), domestic abuse (24%), emotional abuse (62%), and witnessing trauma (39%). In addition, Ghafoori et al. (2014a) found that the average number of traumas reported by Black males was 7.4, with assaultive trauma averages totaling 1.9 and non-assaultive trauma averages totaling 5.5.

The deleterious mental health outcomes for Black men across studies largely consisted of post-traumatic stress disorder, depression, schizophrenia, anxiety disorder, substance abuse, and psychiatric comorbidities. Rates of post-traumatic stress disorder ranged from 12-22%, while rates of depression ranged from 15-28%. The rate of schizophrenia identified was 8.6%, rate of generalized anxiety disorder identified was 8.2%, and rates of substance use were 7% for current and 28% for past use. Psychiatric comorbidities with post-traumatic stress disorder appeared common ranging from 17% of Black males having two disorders to 50% having three or more. Roughly 23-31% of black males with post-traumatic stress disorder had depression disorder, 22% had alcohol or substance use disorder, and 5.5% had a diagnosis of bipolar disorder.

Figure 2: Description of studies design, sample, and setting

Citation	Study Design	Sample Demographics	Type of Setting
Davis et al. (2008)	Cross-sectional	97.3% Black and 41% male Civilian population	Urban nonpsychiatric hospital clinic
Ghafoori et al., (2014a)	Cross-sectional	45% Black and 66% male Civilian population	Health and mental health facility
Ghafoori et al. (2014b)	Cross-sectional	52.2% Black and 61% male Civilian population	Urban community health clinic
Rhoades et al. (2014)	Cross-sectional	71.6% Black and 100% male Civilian population	Community
Sripada et al. (2015)	Cross-sectional	12.9% Black and 28% male Civilian population	Community
Wiechelt et al. (2009)	Cross-sectional	25% Blacks and 46% male Civilian population	Mental Health facility

Table 2: Description of how studies measured trauma, mental health service use, barriers and facilitators to mental health service use

Citation	Trauma Measures	Measure of Mental Health Service Use	Measure of Barriers to Mental Health Service Use	Measure of Facilitators to Mental Health Service Use
Davis et al. (2008)	The Traumatic Events Inventory	Lifetime utilization	16-item Barriers to Need Questionnaire	N/A
Ghafoori et al., (2014a)	The Stressful Life Events Screening Questionnaire	Current utilization	Qualitative Semi-structured interviews were conducted to explore perceived barriers	N/A
Ghafoori et al. (2014b)	The Life Events Checklist	Current utilization	Participants selected from the following barriers: (1) Lack of time, (2) Lack of money, (3) Lack of transportation, (4) I do not believe it will help me, (5) Other: Reason:	A History Form
Rhoades et al. (2014)	PC-PTSD Screen	Current utilization	N/A	Personal Network Characteristics
Sripada et al. (2015)	Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria to diagnose PTSD	Lifetime utilization	Sociodemographic measures	12-item Interpersonal Support Evaluation List (ISEL-12)
Wiechelt et al. (2009)	Instrument was developed by authors and participants to assess trauma exposure	Participants were current mental health service recipients	N/A	Instrument was developed by authors and participants to assess perceived facilitators

Barriers and facilitators to mental health service use

Approximately 26% of trauma exposed Black males in this review currently used mental health services and 43% reported using mental health services at one point in their life. Being Black, male, older, and having only a high school education were significantly associated with nonuse of mental health services (Ghafoori et al., 2014a; Ghafoori, Barragan, & Palinkas, 2014b). Ghafoori, Barragan, and Palinkas (2014b) examination of enabling factors revealed that health insurance and income was not significantly associated with mental health service use for Black males, whereas social support (friend, spouse/partner, family) significantly predicted current mental health service use. Data from a sample of Black homeless men revealed that those who visited a drop-in center or accessed alcohol or drug counseling were significantly more likely to use mental health care services (Rhoades et al., 2014). In terms of need characteristics, occupational disability and increased depression symptom severity were significantly associated with current mental health service use (Ghafoori et al., 2014a; Ghafoori, Barragan, & Palinkas, 2014b), whereas greater levels of psychiatric comorbidity and PTSD symptom severity was significantly associated with lifetime service use (Rhoades et al., 2014).

Black males subjectively perceived barriers and facilitators to mental health service use were also examined. Davis et al., (2008) examined perceived individual and institutional barriers to mental health service use among Black males visiting a nonpsychiatric hospital clinic. Findings showed that poor physical health, lack of faith in treatment, high levels of daily crisis, and lack of time were significant individual barriers. In contrast, too much hassle, unaware of steps to obtain services, and service eligibility issues were significant institutional barriers to service use. Similarly, results from an examination of mental health beliefs related to the use of mental health services revealed that fear of the potential effects of medication and a lack of knowledge about the benefits of treatment were reasons why Black males did not seek mental health services for their trauma related symptoms (Ghafoori et al., 2014a). In terms of perceived facilitators to service use, findings from a sample of Black males showed that the majority of participants agreed/strongly agreed that transportation to services (76%) and financial assistance to obtain treatment (69%) are needed to facilitate service use (Wiechelt, Delprino, & Swarthout, 2009).

Discussion

The collection of studies included in this review present compelling evidence concerning trauma exposure, mental illness, and barriers and facilitators to mental health service use for Black males ages 18 and older. The prevalence of trauma exposure and deleterious mental and behavioral outcomes among Black males found in this review are comparable to prior research on this population (Afful et al., 2010; Felitti et al., 1998; Fein, Wade, & Cronholm, 2013; Gillespie et al., 2009; Hovens et al., 2012; Kilpatrick et al., 2013; McLaughlin et al., 2010; Truman & Langton, 2014; Turner & Lloyd, 2003). Despite the potential need for mental health services, findings from this review suggest that 56-74% of Black males exposed to traumatic events may have an unmet need for mental health services.

Before an individual seeks mental health services, they progress through several stages that consist of experiencing symptoms, evaluating the severity and consequences of the symptoms, assessing whether treatment is required, assessing the feasibility of and options for treatment, and deciding whether to seek treatment (Goldberg & Huxley, 1980). Each stage may

serve as a barrier or facilitator to mental health service use. For Black male trauma survivors in the studies reviewed, specific predisposing, enabling, and need factors served as barriers or facilitators to their use of mental health services. Black males with low incomes and no college education were significantly less likely to use mental health services, whereas, disability and psychiatric symptom severity were significantly associated with service use (Davis et al., 2008; Ghafoori et al., 2014a; Ghafoori, Barragan, & Palinkas, 2014b).

Perhaps, a lack of financial resources decreases the ease with which a Black male can decide to spend resources for mental health treatment. Likewise, a lack of education may make it more difficult to understand mental health, mental health treatment, and mental health service systems, while also contributing to a lack of financial resources. On the other hand, the facilitating factors of disability and psychiatric symptom severity may lead to increased Black male mental health service use due to more obvious need presentation, concentrated efforts to intervene, and support from their social network (Ghafoori et al., 2014a).

Although Evidenced-based trauma-informed mental health treatments for trauma survivors are available, use of services is however affected by many interacting factors. Findings from this review revealed that many of the Black males were not using mental health services due to self-reported perceived barriers such as lack of insurance coverage and fear of side effects from medication (Davis et al., 2008; Ghafoori, Barragan, & Palinkas, 2014b). In contrast, self-reported perceived support from friends, spouse/partner, and family members significantly predicted current mental health service utilization (Ghafoori et al., 2014a). Among the Black males who reported mental health service use, the services mostly comprised of outpatient services at a community hospital or health facility with their primary care physician, or substance abuse treatment facility. These findings support prior research that suggest Black males who have experienced trauma, particularly those residing in low-resourced urban communities, are more likely to seek psychiatric treatment in primary care settings than from mental health specialists (Gary, 2005; Institute of Medicine, 2006; Snowden, 2003). Research show that approximately 50% of all mental health related visits are made to a medical clinic or provider, with 90% of these visits specifically being made to primary care practitioners (Prins, Kimerling, & Cameron et al., 1999). Furthermore, when Black men do seek treatment, clinicians in mental health treatment programs regularly overlook their trauma exposure because of a lack of competency in addressing the effects of trauma and their concern for addressing other presenting problems that are more persistent (Cusak et al., 2006; Salyers et al., 2004).

Limitations

This review is limited by the relatively few studies available that examined Black male trauma survivors ages 18 and older use of mental health services and factors that serve as barriers and facilitators to their service use. All of the studies in this review (n = 6) used a cross-sectional design which limits our ability to make causal inferences regarding trauma exposure in relation to barriers and facilitators to mental health service use. Measures used for mental health service use, and barriers and facilitators to service use were self-report. The use of these self-report measures may have minimized findings due to biases that are inherent in self-report. Lastly, although this review targeted all studies focused on barriers and facilitators to mental health service use for Black male trauma survivors ages 18 and older, it is possible that some studies

were not identified and thus not included in this review. Despite the current limitations, results from this review offer implications for future research, practice, and policy.

Implications

One advantage of a systematic review is the ability to use summaries from two or more studies on the same topic to obtain a more precise assessment of the relationship between to variables (Shadish, Cook, & Campbell, 2002). Furthermore, combining results from several studies can lend more credence to the findings than a single study alone. There have been significant changes to the U.S. health care system since the passing of the Affordable Health Care act, which may lead to changes in perceived barriers and facilitators to mental health service use for Black male trauma survivors. Future research should employ a longitudinal design to examine the relationship between trauma and mental health service use for Black men, and individual, familial, and institutional factors that moderate and/or mediate this relationship. It is also important for future research to carefully examine the relationship between cultural perceptions of barriers and facilitators to mental health service use for Black male trauma survivors. Research investigating factors associated with mental health service use is essential for improved mental and behavioral health outcomes and informing policy and practitioners in the mental health care profession.

Due to the prevalence of Black male trauma survivors ages 18 and older use of primary care settings for psychiatric symptoms, primary care providers should provide a safe space for Black men to discuss their traumatic experiences, how they are coping with these experiences, and refer them to a mental health service provider if needed. Practitioners should also be cognizant of social support systems (i.e., peers, family, and spouse/partner) that can be used to facilitate service use for Black male trauma survivors. Furthermore, policies aimed at creating an integrated system of care consisting of primary care, mental health care, and behavioral health care services focused on the traumatic experiences and associated deleterious outcomes of Black males are warranted.

Conclusion

Black males age 18 and older have the highest age adjusted all-cause mortality rate and perhaps the worst health status of any ethnic-sex group in the United States (Rich & Marguerite, 2002; Ravenell et al., 2006). Exposure to trauma, whether through witnessing or direct victimization, is often a daily reality for many Black males (Bertram & Dartt, 2008; Rich et al., 2005). Additionally, having prior experiences of trauma exposure puts one at risk for exposure to traumatic events in the future (Breslau et al., 1991; Cottler, Nishith, & Compton, 2001; Yehuda et al., 2006). This cycle of trauma that encompasses the lives of many Black men ages 18 and older poses tremendous social and economic costs to the victims, their families, society, and the healthcare system. Each year trauma accounts for 41 million emergency department visits, 2.3 million hospital admissions and 192,000 deaths across the nation (National Trauma Institute, 2014). Trauma related to car accidents ($400 billion), child maltreatment ($585 billion), inpatient ($37 billion), and fatal ($214 billion) and nonfatal ($457 billion) injuries result in a lifetime cost of $1.7 trillion dollars for the U.S. economy due to loss of life and wages lost (CDC, 2015; Paniker et al., 2015; Velopulos et al., 2013).

Evidenced-based trauma-informed mental health treatments such as Cognitive Processing Therapy (Resick & Schnicke, 1993), Prolonged Exposure (Foa, Hembree, & Rothbaum, 2007; McLean & Foa 2011), and Eye Movement Desensitization and Reprocessing (Shapiro, 2001) have shown to be effective in treating and reducing the rates of deleterious mental and behavioral outcomes for trauma survivors, which contribute to reductions in health care costs (Foa et al., 2009; Hassija & Cloitre, 2015). Therefore, addressing barriers to mental health service use for Black male trauma survivors is vital to creating a healthier and thriving society. Moreover, it will take a collective effort from researchers, practitioners, mental and behavioral health organizations, and policy makers to eradicate barriers to mental health service use and strengthen support systems for Black male trauma survivors.

References

Afful, S., Strickland, J., Cottler, L., & Bierut, L. (2010). Exposure to trauma: A comparison of cocaine-dependent cases and a community-matched sample. *Drug & Alcohol Dependence, 112(1/2),* 46-53.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andersen, R.M. (1995). Revisiting the behavioral health model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36,* 1-10.

Bertram, R., & Dartt, J. (2008). Post-traumatic stress disorder: A diagnosis for youth from violent, impoverished communities. *Journal of Child & Family Studies, 18(3),* 294-302.

Breslau, N., Chilcoat, H.D., Kessler, R.C., & Davis, G.C. (1999). Previous exposure to trauma and ptsd effects of subsequent trauma: Results from the Detroit area survey of trauma. *American Journal of Psychiatry, 156,* 902–907.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48,* 216–222.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Analysis, Research, and Practice Integration. (2016). *2014 Violence-related all injury causes nonfatal injuries and rates per 100,000*. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Injury Prevention & Control: Data & Statistics (WISQARS). (2015). Fatal injury reports, national, regional and state, 1981 – 2016. Retrieved from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

Cottler, L. B., Nishith, P., & Compton, W. M. (2001). Gender differences in risk factors for trauma exposure and post-traumatic stress disorder among inner-city drug abusers in and out of treatment. *Comprehensive Psychiatry, 42(2),* 111-117.

Cuff, R., & Matheson, F.I. (2015). *Women, trauma & incarceration: What they say, how we work*. Retrieved from http://content.govdelivery.com/accounts/USDOJBOPNIC/bulletins/111206c

Davis, R. G., Ressler, K. J., Schwartz, A .C., Stephens, K. J., & Bradley, R. G. (2008). Treatment barriers for low-income, urban african americans with undiagnosed posttraumatic stress disorder. *Journal of Traumatic Stress, 21(2),* 218–222.

Dube, S., Felitti, V., Dong, M., Chapman, D., Giles, W., & Anda, R. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111(3),* 564-572.

Fein, J., Wade, R., & Cronholm, P. (2013). *Findings from the Philadelphia urban ace survey*. Retrieved from http://www.instituteforsafefamilies.org/sites/default/files/isfFiles/Philadelphia%20Urban%20AC E%20Report%202013.pdf

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ace) study. *American Journal of Preventive Medicine, 14,* 245-258.

Foa, E. B., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for ptsd: Emotional processing of traumatic experiences*: Therapist guide. New York: Oxford University Press.

Foa, E. B., Keane., T.M., Friedman, M.J., & Cohen, J.A. (2009). *Effective treatments for ptsd: Practice guidelines from the international society for traumatic stress studies*. New York, NY: Guilford Press.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26,* 979–999.

Ghafoori, B., Fisher, D.G., Koresteleve, O., & Hong. M. (2014a). Factors associated with mental health service use in urban, impoverished, trauma-exposed adults. *Psychological Services, 11(4),* 451-459.

Ghafoori, B., Barragan, B., & Palinkas, L. (2014b). Mental health service use after trauma exposure: A mixed methods study. *Journal of Nervous and Mental Disease, 202(3),* 239–246.

Gibb, B.E., Chelminski, I., & Zimmerman, M. (2007). Childhood emotional, physical, and sexual abuse, and diagnoses of depressive and anxiety disorders in adult psychiatric outpatients. *Depression and Anxiety, 24(4),* 256-263.

Gillespie, C. F., Bradley, B., Mercer, K., Smith, A. K., Conneely, K., Gapen, M., & Ressler, K. J. (2009). Trauma exposure and stress-related disorders in inner city primary care patients. *General Hospital Psychiatry, 31,* 505–514.

Goldberg, D., & Huxley P. (1980). *Mental health in the community: The pathways to psychiatric care*. London: Tavistock Publications.

Gonzalez, H. M, Vega, W. A, Williams, D. R, Tarraf, W., West, B. T., & Neighbors, H. W. (2010) Depression care in the United States: Too little for too few. *Archives of general psychiatry, 67,* 37-46.

Gorman-Smith, D., Henry, D. B., & Tolan, P. H. (2004). Exposure to community violence and violence perpetration: The protective effects of family functioning. *Journal of Clinical Child & Adolescent Psychology, 33(3),* 439–449.

Graves, J. L. (2001). *The emperor's new clothes: Biological theories of race at the millennium*. New Brunswick, NJ: Rutgers University Press.

Hankerson, S. H., Fenton, M. C., Geier, T. J., Keyes, K. M, Weissman, M. M, Hasin, D. S. (2011). Racial differences in symptoms, comorbidity, and treatment for major depressive disorder among black and white adults. *Journal of the National Medical Association, 103,* 576-584.

Hassija, C. M., & Cloitre, M. (2015). STAIR narrative therapy: A skills focused approach to trauma-related distress. *Current Psychiatry Reviews, 11,* 172-179.

Hines-Martin, V.,Malone,M., Kim, S., & Brown-Piper, A. (2003). Barriers to mental health care access in an african american population. *Issues in Mental Health Nursing, 24,* 237–256.

Hovens, J., Giltay, E.J., Wiersma, J.E., Spinhoven, P., Penninx, B.W.J.H., & Zitman, F.G. (2012). Impact of childhood life events and trauma on the course of depressive and anxiety disorders. *Acta Psychiatrica Scandinavica, 126,* 198–207.

Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK19830/pdf/Bookshelf_NBK19830.pdf

Kessler, R. C., Berglund, P., Demler, O., Jin, R.,Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of dsm-iv disorders in the national community survey replication. *Archives of General Psychiatry, 62,* 593-602.

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E. Zaslavsky, A. M., et al. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine, 352,* 2515–2523.

Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., et al. (2010). Childhood adversities and adult psychopathology in the WHO world mental health surveys. *British Journal of Psychiatry, 197,* 378-385.

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and ptsd prevalence using dsm–4 and dsm–5 criteria. *Journal of Traumatic Stress, 26(5),* 537–547.

Layne, C. M., Greeson, J. P., Ostrowski, S. A., Kim, S., Reading, S., Vivrette, R. L., & Pynoos, R. S. (2014). Cumulative trauma exposure and high risk behavior in adolescence: Findings from the national child traumatic stress network core data set. *Psychological Trauma: Theory, Research, Practice, and Policy, 6(1),* 40-49.

Lochner, C., Seedat, S., Allgulander, C., Kidd, M., Stein, D., & Gerdner, A. (2010). Childhood trauma in adults with social anxiety disorder and panic disorder: A cross-national study. *African Journal of Psychiatry, 13,* 376-381.

Lynch, M., & Cicchetti, D. (1998). An ecological–transactional analysis of children and contexts: The longitudinal interplay among child maltreatment, community violence, and children's symptomatology. *Development and Psychopathology, 10(2),* 235–257.

McLaughlin, K. A., Conron, K. J., Koenen, K. C., & Gilman, S. E. (2010). Childhood adversity, adult stressful life events, and risk of past-year psychiatric disorder: A test of the stress sensitization hypothesis in a population based sample of adults. *Psychological Medicine, 40*, 1647-1658.

McLean, C. P., & Foa, E. B. (2011). Prolonged exposure therapy for post-traumatic stress disorder: A review of evidence and dissemination. *Expert Review of Neurotherapeutics, 11(8),* 1151– 1163.

Mersky, J. P., Topitzes, J. J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse & Neglect, 37(11),* 917-925.

Mezuk, B., Rafferty, J. A., Kershaw, K. N., Hudson, D., Abdou, C.M., Lee, H., Jackson, J. S., et al. (2010). Reconsidering the role of social disadvantage in physical and mental health: Stressful life events, health behaviors, race, and depression. *American Journal of Epidemiology, 172*, 1238–1249.

Moher, D., Liberari, A., Tetzlaff, J., Altman, D., & the PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analysis: The prisma statement. *Annals of Internal Medicine, 151*, 264–269.

National Trauma Institute. (2014). *Trauma statistics*. Retrieved from http://www.nationaltraumainstitute.org/home/trauma_statistics.html

Paniker, J., Graham, S. M., & Harrison, J. W. (2015). Global trauma: The great divide. *Sicot-J, 119*.

Prins A., Kimerling, R., Cameron, R, et al. (1999). *The primary care ptsd screen (PC-PTSD*); Paper presented at: 15th annual meeting of the international society of traumatic stress studies; Miami, FL.

Ravenell, J. E., Johnson, W. E., & Whitaker, E. E. (2006). African-American men's perceptions of health: A focus group study. *Journal of the National Medical Association, 98(4),* 544-550.

Reichert, J., Ruzich, D., & Osher, M. (2015). *Male survivors of urban violence and trauma: A qualitative analysis of jail detainees.* Chicago, IL: Illinois Criminal Justice Information Authority.

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.

Rhoades, H., Wenzel, S. L., Golinelli, D., Tucker, J. S., Kennedy, D. P. & Ewing, B. (2014). Predisposing, enabling and need correlates of mental health treatment utilization among homeless men. *Journal of Community Mental Health, 50,* 943-952.

Rich, J. A., & Grey, C. M. (2005). Pathways to recurrent trauma among young black men: Traumatic stress, substance use, and the "code of the street." *American Journal of Public Health, 95(5),* 816–824.

Rich, J., & Marguerite, R. (2002) *A poor man's plight: Uncovering the disparity in men's health. A series of community voices publications*. Battle Creek, MI: W.K. Kellogg Foundation.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*, 71-83.

Salyers, M. P., Evans, L. J., Bond, G. R., & Meyer, P. S. (2004). Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people

with severe mental illness: Clinician perspectives. *Community Mental Health Journal, 40*, 17-31.

Sansone, R. A., Leung, J. S., & Wiederman, M. W. (2012). Five forms of childhood trauma: Relationships with aggressive behavior in adulthood. *The Primary Care Companion for CNS Disorders, 14(5)*.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton Mifflin.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd Ed.). New York: Guilford Press.

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93,* 239–243.

Sripada, R. K., Pfeiffer, P N., Rauch, S. A. M., & Bohnert, K. M. (2015). Social support and mental health treatment among persons with ptsd: Results of a nationally representative survey. *Psychiatric Services, 66,* 65-71.

Substance Abuse and Mental Health Services Administration Trauma and Justice Strategic Initiative. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Retrieved from http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Sussman, R. W. (2014). *The myth of race: The troubling persistence of an unscientific idea*. Cambridge, MA: Harvard University Press.

Tolin, D., & Breslau, N. (2007). Sex differences in risk of ptsd. *PTSD Research Quarterly, 18(2)*.

Truman, J.L., & Langton, L. (2014). *Criminal victimization, 2013*. Retrieved from http://www.bjs.gov/content/pub/pdf/cv13.pdf

Tummala-Narra, P., Li, Z., Liu, T., & Wang, Y. (2014). Violence exposure and mental health among adolescents: The role ethnic identity and help seeking. *Psychological Trauma: Theory, Research, Practice, and Policy, 6(1),* 8-24.

Turner R. J. & Lloyd, D. A. (2003). Cumulative adversity and drug dependence in young adults: Racial/Ethnic contrasts. *Addiction, 98,* 305–315.

Velopulos, C. G., Enwerem, N. Y., Obirieze, A., Hui, X., Hashmi, Z. G., Scott, V. K., & ... Haider, A. H. (2013). National cost of trauma care by payer status. *The Journal of Surgical Research, 184(1),* 444-449.

Wiechelt, S. A., Delprino, R., & Swarthout, J. A. (2009). Characteristics of traumatic experience and survivor perceptions of mental health services: The 2004–2005 Erie county community trauma survey. *Journal of Aggression, Maltreatment & Trauma, 18,* 484-498.

Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences, 1186,* 69–101.

Wolff, N., & Shi, J. (2012). Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. *International Journal of Environmental Research and Public Health, 9(5),* 1908-1926.

Yehuda, R., Flory, J. D., Southwick, S., & Charney, D. S. (2006). Developing an agenda for translational studies of resilience and vulnerability following trauma exposure. *Annals of the New York Academy of Sciences, 1071(1),* 379-396.

Zuberi, T. (2001). *Thicker than blood: How racial statistics lie*. Minneapolis, MN: University of Minnesota Press.

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Conflicts of Interest

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